DEVELOPMENTAL DISABILITIES PROFILE - *INFORMATION*

1. Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

2. Date of Birth ___ ___ ___ ___ ___ ___ ___ ___

3. Individual's Last Name

4. Individual's First Name

5. MI

6. Street Address

7. City

8. ST

9. Zip Code

10. Phone Number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

11. Co. of Residence

12. Home Co.

13. Medicaid ID Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

14. Gender

	1. Male
	2. Female

15. Ethnicity

	1. White
	2. African American
	3. Native American
	4. Asian/Pacific Islander
	5. Hispanic
	6. Other

16. Residential Status

	1. Living alone
	2. Living with 2 or less persons with MR/DD
	3. Living with 3 to 7 other persons with MR/DD
	4. Living with 8 or more persons with MR/DD
	5. Living with relatives
	6. Living with non-relatives who are not MR/DD
	7. Other

17. Vocational Habilitation Programs (may check up to 3)

	1. Attends school at least 50% of the day in a classroom with people who are not DD
	2. Attends school less than 50% of the day in a classroom with people who are not DD
	3. Generic community activities less than 20 hours per week
	4. Generic community activities 20 or more hours per week
	5. Work environment designed for persons with DD less than 20 hours per week
	6. Work environment designed for persons with DD 20 or more hours per week
	7. Competitive employment less than 20 hours per week
	8. Competitive employment 20 or more hours per week
	9. Agency-based non-work activities less than 20 hours per week
	10. Agency-based non-work activities 20 or more hours per week
	11. Other

18. Identified Developmental Disabilities

Y	N	1. Mental Retardation
Y	N	2. Autism
Y	N	3. Cerebral Palsy
Y	N	4. Epilepsy/Seizure Disorder
Y	N	5. Other (Description):

Enter the number of the one developmental disability from number 18 that best applies:

19. Primary Developmental Disability

20. Type of Evaluation

KEY For #20
1. Initial MCD Eligible
2. Initial Not Medicaid Eligible
3. PAS
4. Significant Change Medicaid
5. Significant Change State Funded
6. Waiver Annual
7. Waiting List LOC

21. Psychiatric Diagnosis

(DSM-IV Codes)

1.	
2.	
3.	

11/19/2001

22. Intellectual Assessment	
1. IQ Score	
2. Test Type	
3. Test Date	
4. Administered by:	

	23. Hearing: (with hearing aid if used)
	1. Normal
	2. Mild Loss
	3. Moderate Loss
	4. Severe Loss
	5. Profound Loss
	6. Undetermined

	24. Vision: (with best correction)
	1. Fully Sighted
	2. Moderate Impairment
	3. Severe Impairment
	4. Light Perception
	5. Total Blindness
	6. Undetermined

Guardian Information

25. Last	First	MI

26. Guardian Phone Number
( ) -

BDDS Service Coordinator Information

27. Last	First	MI

28. Service Coordinator Phone Number
( ) -

Case Manager Information

29. Case Manager #	30. Last	First

31. Case Manager Phone Number
( ) -

Individual's Name

32. Has the person been the alleged perpetrator of any of the following crimes reported to a law enforcement agency, during the past year?

Y	N	**1. Rape**
Y	N	**2. Simple Assault**
Y	N	**3. Sexual Assault**
Y	N	**4. Household Burglary**
Y	N	**5. Theft**
Y	N	**6. Aggravated Assault**
Y	N	**7. Other**

33. Police involvement due to maladaptive behaviors?

1. Yes	2. No

34. Client requires two or more staff on-site for any part of the day, for more than 30 days.

1. Yes	2. No

37. Significant medical conditions requiring specialized medical supports or that significantly interfere with participation in services?

1. YES
2. NO

35. If barriers to the person achieving opportunities for personal independence, productivity, integration and/or community inclusion, have been identified, such barriers result primarily from which of the following (Rank up to three in order) (1, 2, and/or 3):

	1. Transportation
	2. The level of medical supports needed
	3. The level of behavior supports needed
	4. Imminent significant danger to the person's health, safety or welfare
	5. Currently inadequate exploration of options or responsiveness to identified preferences or needs
	6. Risk to funding access
	7. Opinions or beliefs of person's guardian
	8. Opinions or beliefs of person's family
	9. Other / None

36. If barriers to the person achieving his/her identified lifestyle and related needs, have been identified, such barriers result primarily from which of the following (Select up to three in rank order) (1, 2, and/or 3):

	1. Transportation
	2. The level of medical supports needed
	3. The level of behavior supports needed
	4.Imminent significant danger to the person's health, safety or welfare
	5. Currently inadequate exploration of options or responsiveness to identified preferences or needs
	6.Risk to funding access
	7.Opinions or beliefs of person's guardian
	8. Opinions or beliefs of person's family
	9. Other / None

38. Indicate how often the individual has utilized or required any of these health-related services in the past year (Key A). Over the past year, if any of these health-related services have been needed, but not utilized, indicate the factor limiting/preventing those services (Key B). If there are no Limiting Factors, use Zero (0):

	Key A	Key B
1. Primary Medical Care		
2. Medical Specialists		
3. Dental Services		
4. Ancillary Health Services		
5. Vision Services		
6. Mental Health Services		
7. Durable Medical Equipment		
8.Home Health Services		
9.Assistive Technology		
10. Other		

#38. Key A - Frequency of Services:	
Not this year	1
Occasionally	2
Monthly	3
Weekly	4
Frequently	5
Daily	6
	7
	8

#38 Key B - Factors Preventing Services:
Not available in immediate or nearby community
Service provider will not accept person's insurance
Service provider will not accept person due to DD
Financial limitations of the person
Currently inadequate exploration of options/responsiveness to need
Opinions or beliefs of person's guardian
Opinions or beliefs of person's family
Other

Example: John Doe requires **#3. Dental Services** "Frequently" (Key A = 5), but does not receive due to "Financial Limitations" (Key B = 4).

Individual's Name >>

ASSESSMENT

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Individual's Last _____ **First** _____ **MI** _____

1a. Primary Provider Agency

1b. Assessment Date

2. Preferred Language

	1. English
	2. Spanish
	3. American Sign
	4. Other

3. Medical Conditions - Circle "yes" or "no" for each of the following:

Y	N	1. Respiratory
Y	N	2. Cardiovascular
Y	N	3. Gastro-Intestinal
Y	N	4. Genito-Urinary
Y	N	5. Neoplastic Disease
Y	N	6. Neurological Diseases

4a. Does Individual have history of seizures?

1. Yes	2. No

(Enter Informant's 'Relationship' to Individual below)

1c. Name of Informant (below)

4b. Type of Seizures - Which type of seizure has the individual experienced in the last twelve months? (Check all that apply)

	1. No seizures this year
	2. Simple partial (Simple motor movements affected; no loss of awareness)
	3. Complex partial (Loss of awareness)
	4. Generalized - Absence (Petit Mal)
	5. Generalized - Tonic-Clonic (Grand Mal)
	6. Had some type of seizure-not sure of type

4c. Frequency of Seizures - In the past year how frequently has the individual experienced seizures that involve loss of awareness and/or loss of consciousness?

	1. None during past year
	2. Less than once a month
	3. About once a month
	4. About once a week
	5. Several times a week
	6. Once a day or more

5a. Medications - Is individual currently taking prescription medication?

1. Yes	2. No

5b. Prescribed Medications - Circle all prescription medications individual receives Not Currently = 1, Currently = 2

1. Antipsychotic medication	1	2
2. Antianxiety medication	1	2
3. Antidepressant medication	1	2
4. Anticonvulsant medication	1	2
5. Diabetes medication	1	2
6. Sedative/hypnotic medication	1	2
7. Other maintenance medication	1	2

5c. Injections - Does Individual receive medication by injection?

1. Yes	2. No

5d. Medication Support - Which best describes the level of support the Individual receives when taking prescription medications

	1. Total Support
	2. Assistance
	3. Supervision
	4. Independent

6. Medical Consequences - Circle whether or not the individual:

Y	N	1. Missed more than a total of two weeks of regular activities due to medical conditions during the last year
Y	N	2. Was hospitalized for a medical problem in the last year
Y	N	3. Presently requires care giver be trained in special health care procedures (e.g., ostomy care, positioning, adaptive devices)
Y	N	4. Presently requires special diet planned by dietician, nutritionist, nurse, (e.g., high fiber, low calories, low sodium, pureed)

7. Mobility - Indicate which one response best describes the individual's typical level of mobility	
	1. Walks Independently
	2. Walks Independently but with difficulty
	3. Walks Independently w/corrective device
	4. Walks only with assistance from another person
	5. Can not walk

8a. Wheelchair - Does Individual use a wheelchair?	
1. Yes	2. No

8b. Wheelchair Mobility - Check the one response that best describes the individual's wheelchair mobility	
	1. Can use wheelchair independently, including transferring
	2. Can use wheelchair independently with assistance in transferring
	3. Requires assistance in transferring and moving
	4. No Mobility - Must be transferred and moved

9. Motor Control - Circle to indicate whether or not the individual:		
Y	N	1. Can roll from back to stomach
Y	N	2. Can pull self to standing
Y	N	3. Can walk up and down stairs by alternating feet from step to step
Y	N	4. Can pick up small object
Y	N	5. Can transfer an object from hand to hand
Y	N	6. Can mark with pencil, crayon or chalk
Y	N	7. Can turn pages of a book one at a time
Y	N	8. Can copy a circle from an example
Y	N	9. Can cut with scissors along a straight line

10. Cognitive Ability - Circle to indicate whether or not the individual can perform each of the following:		
Y	N	1. Sort objects by size
Y	N	2. Correctly spell first and last name
Y	N	3. Tell time to nearest five minutes (digital or analog)
Y	N	4. Distinguish between right and left
Y	N	5. Count ten or more objects
Y	N	6. Understand simple functional signs (e.g., EXIT, Restrooms)
Y	N	7. Do simple addition and subtraction
Y	N	8. Read and comprehend simple sentences
Y	N	9. Read and comprehend newspaper or magazine articles

11. Communication - Circle to indicate whether or not the individual typically displays each of the following receptive and expressive communication skills:		
Y	N	1. Understands the meaning of "No"
Y	N	2. Understands one-step instructions (e.g., "Put on your coat.")
Y	N	3. Understands two-step instructions (e.g., "Put on your coat, then go outside.")
Y	N	4. Understands a joke or story
Y	N	5. Indicates a "Yes" or "No" response to a simple question
Y	N	6. Asks simple questions
Y	N	7. Relates experiences when asked
Y	N	8. Tells a story, joke, or the plot of a television show
Y	N	9. Describes realistic plans in detail

Individual's Name

12. Behavior Frequency - Circle to indicate the frequency of each behavior over the last twelve months

KEY for #12	
1	Not this Year
2	Occasionally (Less than than once a month)
3	Monthly (About once each month)
4	Weekly (About once each month)
5	Frequently (Several times a week)
6	Daily (Once each day or more)

1. Has tantrums or emotional outbursts	1	2	3	4	5	6
2. Damages own property or that of others	1	2	3	4	5	6
3. Physically assaults others	1	2	3	4	5	6
4. Disrupts activities of others	1	2	3	4	5	6
5. Is verbally or gesturally abusive	1	2	3	4	5	6
6. Is self-injurious	1	2	3	4	5	6
7. Resists supervision	1	2	3	4	5	6
8. Runs or wanders away	1	2	3	4	5	6
9. Steals	1	2	3	4	5	6
10. Displays sexually inappropriate behavior	1	2	3	4	5	6

13. Behavior Consequences - Circle any of the following that apply as a result of any behavior problem(s)

Y	N	1. Behavior problems currently prevent Individual from moving to a less restrictive setting?
Y	N	2. Has a written behavior intervention plan?
Y	N	3. Individual's environment must be carefully structured to avoid behavior problems
Y	N	4. Because of behavior problems, staff must sometimes intervene physically with individual (e.g., physically restrain individual or guide individual from room)
Y	N	5. Because of behavior problems, a supervised "time-out" period is needed at least once a week
Y	N	6. Because of behavior problems, the individual requires one-on-one supervision for many program activities

14. Self Care - As accurately as possible, circle to indicate how independently the individual typically performs each activity

KEY for #14	
1	Total Support (Completely Dependent)
2	Assistance (Needs lots of hands-on-help)
3	Supervision (Needs mainly verbal prompts)
4	Independent (Starts and finishes without prompts or help)

1. Toileting/bowels	1	2	3	4
2. Toileting/bladder	1	2	3	4
3. Taking a shower/bath	1	2	3	4
4. Brushing teeth / cleaning dentures	1	2	3	4
5. Brushing/combing hair	1	2	3	4
6. Selecting clothes appropriate to weather	1	2	3	4
7. Putting on clothes	1	2	3	4
8. Undressing Self	1	2	3	4
9. Drinking from a cup/glass	1	2	3	4
10. Chewing and swallowing food	1	2	3	4
11. Feeding self	1	2	3	4

Individual's Name

15. Daily Living Skills - As accurately as possible, circle to indicate how independently the individual typically performs each activity

KEY for #15	
1.	Total Support (Completely Dependent)
2.	Assistance (Needs lots of hands-on-help)
3.	Supervision (Needs mainly verbal prompts)
4.	Independent (Starts and finishes without prompts or help)

1. Making bed	1	2	3	4
2. Cleaning room	1	2	3	4
3. Doing laundry	1	2	3	4
4. Using telephone	1	2	3	4
5. Shopping for a simple meal	1	2	3	4
6. Preparing foods that do not require cooking	1	2	3	4
7. Using stove or microwave	1	2	3	4
8. Crossing street in residential neighborhood	1	2	3	4
9. Using public transportation for a simple direct trip	1	2	3	4
10. Managing own money	1	2	3	4

16. Clinical Services - Circle to indicate how often the individual receives services from the following clinical specialists provided or funded by Medicaid or State funding

	NOT THIS YEAR	OCCASIONALLY *Less than once a month*	MONTHLY *About once a month*	WEEKLY *About once a week*	FREQUENTLY *Several time a week*	DAILY *Once a day or more*
1. Psychologist	1	2	3	4	5	6
2. Psychiatrist	1	2	3	4	5	6
3. Speech and Hearing Pathologist	1	2	3	4	5	6
4. Physical Therapist	1	2	3	4	5	6
5. Occupational Therapist	1	2	3	4	5	6
6. Physician	1	2	3	4	5	6
7. Nurse	1	2	3	4	5	6
8. Social Worker	1	2	3	4	5	6

Assessment Completed by:

17. Last First

18. Phone Number ( ) -

Individual's Name

DEVELOPMENTAL DISABILITIES PROFILE - *CHILDREN'S ASSESSMENT*

For children physically older than five (5) who have not yet attained their eleventh (11th) birthday

Child's Name	

Key	
1	= Not a Problem
2	= Suspected Problem; Assessment Pending
3	= Moderate Problem
4	= Severe Problem*

**** Severe problems are those that require intensive treatment efforts, lots of hands-on care and close supervision.***

19. Circle the number best describing this child's functioning in each of the following ten domains, as compared to a peer of the same age without problems. Answers must be based on personal knowledge, observation, interviews, or available documentation.

1. Ambulation and Mobility	1	2	3	4
2. Fine Motor	1	2	3	4
3. Receptive Communication	1	2	3	4
4. Expressive Communication	1	2	3	4
5. Vision without Glasses	1	2	3	4
6. Hearing without Aid	1	2	3	4
7. Self- Care (e.g. eating, drinking, dressing, bathing, grooming…)	1	2	3	4
8. Emotional Problems (e.g. withdrawn, stereotypic behaviors, highly anxious…)	1	2	3	4
9. Social Skills (e.g. making eye contact, making friends, getting along, being appropriately affectionate…)	1	2	3	4
10. Problem Behavior (e.g. self-injurious, aggressive, destructive, resistive, inattentive, hyperactive, impulsive, runs away…)	1	2	3	4

Assessment Completed by:

Last	First	Phone Number
		( ) -

THE DEVELOPMENTAL DISABILITIES PROFILE

INSTRUCTIONS FOR COMPLETING THE DEVELOPMENTAL DISABILITIES PROFILE AND ADDENDUM FOR CHILDREN AGES 5 - 10

Indiana Bureau of Developmental Disabilities Services

Revised February 11, 2001

The Developmental Disabilities Profile (DDP) is an **informant-based** tool. It can be administered with the individual, a reliable informant or with both. Only one informant is necessary to complete the DDP. The informant should be someone who best knows the individual. If the individual has 24 hour paid staff, a staff person may be the most qualified informant that that individual. In other cases, a parent or friend may be spending more time with the individual than anyone else.

If the individual or the informant is not reliable or capable of answering the questions, the administrator should seek another informant, if possible. If the informant cannot answer some of the questions or the administrator believes the informant is not reliable, the administrator of the DDP should examine collateral information.

If the collateral information does not contain an answer for some of the questions, the **administrator** must complete the remaining questions, based on their reasoned understanding of the individual's functioning. **The computer systems in which the DDP will be completed will not score any DDP which has questions unanswered.**

For children ages 11 – 17 and for adults, answer the individual component of all questions through page 7, leaving NONE blank. If the answer for a particular question is not known for certain, the person administering the DDP (or the informant) should answer the question, based on of his/her knowledge of the individual. In these cases, the DDP allows for judgement in determining of the individual is capable of completing certain tasks. For example, if an individual is bald, estimate his or her ability for hair grooming, based on that individual's functioning in other hygiene/grooming skills.

For children ages 5 – 10, answer the individual components of all questions, including the children's addendum on page 8, leaving NONE blank. Children in this age group must have the original DDP and the children's addendum administered. Again, if the answer for a particular question is not known for certain, the person administering the DDP (or the informant) should answer the question, based on of his/her knowledge of the individual. In these cases, the DDP allows for judgement in determining of the individual is capable of completing certain tasks.

The DDP is not meant to be an all-encompassing picture of the individual. Instead, it is a "snap shot" of what the individual is capable of at the time of the assessment.

INFORMATION
PAGES 1-3

1. **Social Security Number**
   Enter the individual's own nine digit social security number.

2. **Date of Birth**
   Enter the individual's 2-digit month, 2-digit day and four-digit year of birth.

3. **Last Name**
   Enter the last name of the individual.

4. **First Name**
   Enter the first name of the individual.

5. **Middle Initial**
   Enter the middle initial of the individual.

6. **Street Address**
   Enter the individual's street address.

7. **City**
   Enter the city in which the individual resides.

8. **State**
   Enter the 2 initials of the state in which the individual resides.

9. **Zip Code**
   Enter the 5-digit zip code in which the individual resides. See attachment A.

10. **Phone Number**
    Enter the phone number (area code and seven digits number) for the individual.

11. **County of Residence**
    Enter the 2 digit county number in which the individual resides.

12. **Home County**
    Enter the 2 digit county number in which the individual initially resided.

13. **Medicaid ID Number**
    Enter the individual's Medicaid identification number.

14. **Gender**
    Check the appropriate box indicating the gender of the individual.

15. **Ethnicity**
    Check the appropriate box indicating the ethnicity of the individual.

16. **Residential Status**
    Check the appropriate box indicating the residential status of the individual. If other, indicate the type.

17. **Vocational/Habilitation Programs**
    Check the type of program that the individual is involved in. Up to three categories can be checked. If other, indicate the type.

18. **Identified Developmental Disabilities**
    Circle "y" (yes) or "n" (no) indicating what best describes the individual's developmental disability. More than one category can be checked. Enter a description of any other developmental disability in #5, as needed.

19. **Primary Developmental Disability**
    Enter the number of the one developmental disability from number 18 that best identifies the individual's primary developmental disability.

20. **Type of Evaluation**
    Check the one type of evaluation that is being completed.

    INITIAL MCD ELIGIBLE: Initial evaluation, eligible for Medicaid (including Waivers) and funded by Medicaid.

    INITIAL NOT MCD ELIGIBLE: Initial evaluation, not eligible for Medicaid and state funded.

    PAS: Pre-Admission Screening

    SIGNIFICANT CHANGE MCD: Need for an evaluation due to significant changes, eligible for Medicaid (including Waivers) and funded by Medicaid.

    SIGNIFICANT CHANGE State Funded: Need for an evaluation due to significant changes, not eligible for Medicaid and state funded.

    WAIVER ANNUAL EVALUATION: Annual evaluation for a waiver funded program.

    WAITING LIST LOC: Evaluation to determine applicability for waiver waiting list.

21. **Psychiatric Diagnosis**
    Enter the 5 digit DSM-IV Codes relating to the individual's psychiatric diagnosis, if applicable.

22. **Intellectual Assessment**
    Enter 1. the individual's valid IQ score, 2. the name of the test utilized, 3. the date of the test, and 4. the name of the person who administered the test.

23. **Hearing**

Check the category that best describes the hearing ability of the individual. This should be indicative of the individual's hearing with the use of hearing aids, as applicable. If an individual is deaf in one ear and has normal hearing in the other ear, a moderate loss would be indicated.

24. **Vision**

Check the category that best describes the vision of the individual. This should be indicative of the individual's vision with best correction. If an individual is blind in one eye and has normal vision in the other eye, a moderate impairment would be indicated.

Guardian Information

25. **Guardian Name**

Enter the last name, first name and middle initial of the guardian, leaving a space between each.

26. **Guardian Phone Number**

Enter the phone number of the individual's guardian.

BDDS Service Coordinator Information

27. **BDDS Service Coordinator Name**

Enter the last name and first name of the BDDS Service Coordinator, leaving a space between each.

28. **BDDS Service Coordinator Phone Number**

Enter the phone number for the BDDS Service Coordinator.

Case Manager Information

29. **Case Manager Number**

Enter the six-digit code associated with the Case Manager as identified through the Medicaid Waiver number. BDDS staff will be assigned numbers.

30. **Case Manager Name**

Enter the last name and first name of the Case Manager, leaving a space between each.

31. **Case Manager Phone Number**

Enter the phone number for the Case Manager.

32. **Has the person been the alleged perpetrator of any of the following crimes reported to a law enforcement agency during the last year?**

Circle "Y" (for yes) or "N" (for no) for each crime.

33. **Police involvement due to maladaptive behaviors?**

Circle "Yes" or "No."

34. **Client requires two or more staff on-site for any part of the day, for more than 30 days.**
    Circle "Yes" or "No."

35. **If barriers to the person achieving opportunities for personal independence, productivity, integration and/or community inclusion have been identified, such barriers result primarily from which of the following?**
    If any of the listed choices are limiting the individual's opportunities, rank the three most important in order of importance - with the most important barrier ranked number 1 and the least important of the barriers ranked number 3. Write the number in the box to the left of the corresponding barrier. If none of these are barriers for the individual, write "9" next to "Other/None."

36. **If barriers to the person achieving his/her identified lifestyle and related needs have been identified, such barriers result primarily from which of the following?**
    If any of the listed choices are preventing the individual from achieving his/her identified lifestyle and needs, rank the three most important in order of importance - with the most important barrier ranked number 1 and the least important of the barriers ranked number 3. Write the number in the box to the left of the corresponding barrier. If note of these are barriers for the individual, write "9" next to "Other/None."

37. **Significant medical conditions requiring specialized medical supports or that significantly interfere with participation in services?**
    Circle "Yes" or "No."

38. **Indicate how often the individual has utilized or required any of these health-related services in the past year (Key A), Over the past year, if any of these health related services have been needed, but not utilized, indicate the factor limiting/preventing those services (Key B).**
    Answers for Key A and Key B are to the **right** of the question #38. The numbers listed between Key A and Key B correspond with a particular answer in each Key. Use the text list in each key to find the corresponding number then list only the number, not the text, as answers.

    Use the list in "Key A – Frequency of Services" to describe the frequency a particular service has been utilized. For example, if Primary Medicaid Care has been utilized occasionally in the last year, a "2" should be recorded in the Key A column next to Primary Medicaid Care. Please use the choices in Key A to answer in the column labeled Key A next to each choice.

    Use the list in "Key B – Factors Preventing Services" to describe the reasons why the individual has not been able to utilize needed medical services or why utilization has been limited. For example, If the individual needed Primary Medicaid Care, but has not been able to utilize it due to the opinions or beliefs of the person's guardian, a "6" should be placed in the Key B column next to Primary Medicaid Care. Please use the choices in Key B to answer in the column labeled Key B next to each choice.

ASSESSMENT
PAGE 4-7

ENTER THE SOCIAL SECURITY NUMBER AND NAME (LAST, FIRST AND MIDDLE INITIAL) OF THE INDIVIDUAL WHO IS BEING EVALUATED.

1a. **Primary Provider Agency**
Enter the name of the individual's primary service provider.

1b. **Assessment Date**
Enter the date in which the DDP assessment was completed. Enter the 2-digit month, 2-digit day and four-digit year.

1c. **Name of Informant**
Enter the name of the informant. To the right enter the informant's relationship to the individual e.g. mother, brother, residential staff etc.

2. **Preferred Language**
Check the box of the preferred method of communication used by and understood by the individual. If other, indicate the preferred mode.

3. **Medical Conditions**
Indicate by circling "y" (yes) if the individual actually has the condition at the present time. If the person is currently being screened or tested for one of the listed conditions, or does not have the condition, circle "n" (no) for that category.

4a. **Seizure History**
Indicate by circling "Yes (1)" if the individual has any history of seizure activity and proceed to questions 4b and 4c. Circle "No (2)" if the individual has no seizure history and skip to question 5a.

4b. **Type of Seizures**
Check all types of seizures the individual has experienced in the last twelve months. If the individual has not had any seizures in the last twelve months, check the first box – "No seizures this year" and go to 5a. If you know that the individual has had a seizure but are unsure of the type of seizure, check the last box – "Had some type of seizure – not sure of type", experienced in the last twelve months. Multiple checks may be supplied. Generalized – tonic-clonic (Grand Mal) seizures are often characterized by being incontinent.

4c. **Frequency of Seizures**
Check the <u>one</u> category, which indicates how frequently the individual has experienced seizures that involve loss of awareness and/or loss of consciousness in the last twelve months. If an individual's seizures are very episodic or cyclical in nature, report the frequency of the episodes over the last twelve months rather than the individual occurrences.

Example: If a person has seizures several times a week, circle #5 for "Several times a week". However, if an individual is seizure free, yet has several seizures throughout one or two weeks during the year, treat this as episodic in nature and circle #2 for "Less than once a month".

5a. **Medications**

Circle "Yes (1)" if the individual is currently taking any prescription medication and "No (2)" if the individual is not currently taking prescription medication. If "No (2), proceed to question 6.

5b. **Prescribed Medication**

Circle "1" for any medications that the individual is not currently taking. Indicate by circling "2" if the individual is currently taking any of the identified medications. Medication should be restricted to maintenance medications given on an ongoing basis.

5c. **Injections**

Circle "yes (1)" if the individual is receiving ongoing medication by injection. Circle "No (2)" if the individual is not receiving ongoing medication by injection.

5d. **Medication Support**

Check the level of support the individual receives when taking prescription medication. Levels of support are defined as follows:

1. TOTAL SUPPORT: The staff or caregiver must physically administer medications by such means as injections, drops, mixed in food, or the individual is physically incapable of taking medications or is often resistive (spits out or refuses to swallow it).

2. ASSISTANCE: The staff or caregiver keeps the medication(s) and gives it (them) to the individual at the appropriate time for self-administration.

3. SUPERVISION: The individual keeps or takes his/her own medication, but the staff or caregiver may have to prompt or confirm that he/she has indeed taken it.

4. INDEPENDENT: The individual is totally responsible for his/her own medications.

If the individual takes more than one medication and the support is provided at different levels, i.e. tablets and injections check the one that indicates more support. CHECK ONLY ONE RESPONSE.

6. **Medical Consequences**

This question relates to the programming consequences of an individual's medical condition. Consider all aspects of the individual's medical condition. Circle "y" (yes) or "n" (no), as applicable.

7. **Mobility**

Check the one response that best describes the individual's typical level of mobility. Note that choice #2, "Walks independently, but with difficulty", involves walking unaided; choice #3, "Walks independently with corrective device", involves the use of a corrective device such as a cane or walker. Choice #4, "Walks only with assistance from another person", means that the individual needs some help from another person when walking. Include sensory deficits in your assessment if they are a significant impediment to mobility. If the individual is able to ambulate within their home, however unable to walk long distances without a wheelchair or other support, circle #3.

8a. **Wheelchair**

Circle "Yes (1)" if the individual uses a wheelchair for any reason. If the individual does not use a wheelchair at all, circle "No (2)" and skip to question 9.

8b. **Wheelchair Mobility**

Check the one answer that best describes the individual's wheelchair mobility. The wheelchair may be motorized.

9. **Motor Control**

Circle "y" (yes) or "n" (no) for each item. Base your response primarily on personal knowledge and observation of the individual and only secondarily on the individual's records.

These questions should be viewed as whether or not the person is presently capable of doing these things.

It is suggested that the assessor use pins, blocks, or lifesavers to determine an individual's ability to pick up small objects. In most cases, these items should be tested directed. However, if you have not had the opportunity to observe the individual perform a particular task e.g. the item "Can cut with scissors along a straight line", estimate his/her ability to perform that task based on similar tasks you have observed the individual perform. Base your answers only on the individual's capabilities and not on his/her willingness or unwillingness to engage in these activities.

10. **Cognitive Ability**

Circle "y" (yes) or "n" (no) for each item. This question attempts to determine cognitive abilities. The individual may have to be prompted verbally, but base your answers only on the individual's capabilities as in the previous question. For each of the items generalize his/her ability to other settings.

"Understand simple functional signs" – the individual should be able to recognize and understand exit signs or restroom signs whenever he or she encounters them.

The ability to distinguish right from left can be determined by holding your own hands up and asking the individual to identify which is your right or left hand. The ability to do simple addition or subtraction can be determined of asking the individual to complete simple single digit samples. This might also be determined by asking the individual how many marbles he/she would have if they had seven and lost one. It is suggested that an individual's ability to tell time be evaluated by showing several "times" on sheets of paper. See Attachment B for examples that can be used in the assessment process.

11. **Communication**

Circle "y" (yes) or "n" (no) for each item. The mode of receptive and expressive communication skills can be written, verbal, sign, symbolic, or electronic.

The ability to understand a joke or story may be determined by telling a joke or story and then discussing this with the individual to determine their level of understanding. A simple example would be "Why did the chicken cross the road? To get to the other side!" The ability to tell a story or the plot of a television show might be determined by asking the individual what their favorite television show is and then asking what happened in the last episode. The ability to describe realistic plans in detail might be determined by asking the individual what their plans are for the next weekend.

12. **Behavior Frequency**

Restrict answers to behaviors observed, even if you are aware of problems exhibited by the person at other times and in other settings. Evaluate this based on the environment reflects the most behavioral problems or need for intervention. When trying to describe someone's behavior, carefully consider into which category a given behavior fits. Select the most appropriate category and do not count the same behaviors in several behavior categories. Base your rating on a single episode. Much of this information can be obtained from the individual's program plan and records reflecting current behaviors.

Circle the appropriate frequency for each of the items using the following code:

1. Not this year
2. Occasionally (less than once a month)
3. Monthly (About once a month)
4. Weekly (About once a week)
5. Frequently (Several times a week)
6. Daily (Once a day or more)

If a person has tantrums several times a week, circle # 5 for "Frequently". However, if a person is usually calm yet has several emotional outbursts

throughout one or two days during the month, threat this as episodic in nature and circle # 3 for “Monthly”.

13. **Behavior Consequences**
Circle “y” (yes) or “n” (no) for each consequence of an individual’s behavior. Keep in mind the following guidelines.

Record behavior consequences only as you see them.

Respond based on what has happened as a result of any behavior on the part of the individual, not just those listed in previous questions.

This relates to only asking about the results of the individual’s behavior.

“Environment” refers to program areas where an individual lives and works. Chose the environment in which the individual has the most needs. Some examples include locks on all doors to prevent the individual from leaving, requires a private room to avoid problems, or locked dressers to prevent stealing. “Time-out” should be related to a formal behavior plan.

14. And 15. **Self Care and Daily Living Skills**
Circle the appropriate number (1-4) for each item. We are interested here in how well the individual performs these activities as stated in each item from start to finish at a reasonably acceptable level.

1. TOTAL SUPPORT: The individual is completely dependent of others to carry out activities on his/her behalf. Total support requires that the provider or caregiver be involved throughout the task. (Depending)

2. ASSISTANCE: The individual often requires physical aid in order to accomplish tasks. The service provider or caregiver would offer regular verbal prompting and instructions as well as regular physical hands-on aid. (Helping)

3. SUPERVISION: The individual is able to perform tasks with some verbal direction. The individual usually understands the need for and is usually willing to perform a task. (Reminding)

4. INDEPENDENT: The individual understands the need for, is willing to and can perform tasks with no prompting. The individual may need supervision and/or assistance in exceptional circumstances.

Where the program does not really allow someone to perform a certain activity, we would like an estimate of the individual’s ability to perform this task independently. For example, if an individual is bald, evaluate their ability for hair grooming.

Putting on clothes relates to the individual’s ability to put clothes on, not if they are capable of selecting appropriate clothes.

Feeding self refers to just being able to feed oneself once the food is on the table, not being able to cook or prepare food. If an individual feeds themselves with their hands, then they are independent in feeding. If the individual is able to feed themselves, however is very messy and perhaps losing weight, then they would need total support.

If an individual receives a pureed or ground diet because they have problems chewing, then #2 – assistance would be circled. If the individual needs help swallowing, circle #1 – total support.

In Daily Living Skills – managing money includes such activities as budget making and using bank services.

16. **Clinical Services**
Circle the appropriate number (1-6) for each item. Indicate only those services provided or funded by Medicaid or state funding.

Include direct service to the person or any supervision of that service by the clinical specialist. Also include services provided by other specialists or assistants under the direct and regular supervision of the clinical specialist listed. These other specialists and assistants include psychologist with master's degree, physical therapist assistant, occupational therapist assistant, licensed practical nurse (LPN), and social worker with a bachelor's degree. For item h, "Social Worker", include service given to immediate family members or guardian as service received by the individual.

If there was a brief break in an otherwise regular service due to a temporary inability to provide the service (for example, a clinician leaves and it takes a month or two to replace him/her), indicate the frequency with which the person was scheduled to receive the service.

Mark only one response on each row. In the case where there was only an assessment (by a physician, for instance) in the last year, circle #2, "Occasionally". Circle #1, "Not this year", for services not provided with Medicaid or state funding.

Do not mark services provided by other programs even though you may be aware of them.

17. **Assessment Completed by**
Enter the last name and first name of the individual completing the assessment.

18. **Phone Number**
Enter the phone number of the individual completing the assessment.

INSTRUCTIONS FOR ADDENDUM TO THE DDP FOR CHILDREN AGES 5 – 10.

Child's Name: Complete last name, then first name and middle initial.

19. Circle the number that best described the child's functioning for each question (1 – 10) using the Key on the left.

Remember: The scoring scale is 1 – 4, with "1" indicating that the child has no problems with that particular domain, while a "4" indicates a severe problem requiring intensive treatment efforts, much hands-on care and close supervision.

Assessment Completed By: Enter the Last, then first, name of the individual who administered the assessment.

Phone Number: Enter the phone number of the individual who administered the assessment.

ATTACHMENT A

County Numbers and Names

01 ADAMS		47 LAWRENCE		
02 ALLEN		48 MADISON		
03 BARTHOLOMEW		49 MARION		
04 BENTON		50 MARSHALL		
05 BLACKFORD		51 MARTIN		
06 BOONE		52 MIAMI		
07 BROWN		53 MONROE		
08 CARROLL		54 MONTGOMERY		
09 CASS		55 MORGAN		
10 CLARK		56 NEWTON		
11 CLAY		57 NOBLE		
12 CLINTON		58 OHIO		
13 CRAWFORD		59 ORANGE		
14 DAVIESS		60 OWEN		
15 DEARBORN		61 PARKE		
16 DECATUR		62 PERRY		
17 DEKALB		63 PIKE		
18 DELAWARE		64 PORTER		
19 DUBOIS		65 POSEY		
20 ELKHART		66 PULASKI		
21 FAYETTE		67 PUTNAM		
22 FLOYD		68 RANDOLPH		
23 FOUNTAIN		69 RIPLEY		
24 FRANKLIN		70 RUSH		
25 FULTON		71 ST. JOSEPH		
26 GIBSON		72 SCOTT		
27 GRANT		73 SHELBY		
28 GREENE		74 SPENCER		
29 HAMILTON		75 STARKE		
30 HANCOCK		76 STEUBEN		
31 HARRISON		77 SULLIVAN		
32 HENDRICKS		78 SWITZERLAND		
33 HENRY		79 TIPPECANOE		
34 HOWARD		80 TIPTON		
35 HUNTINGTON		81 UNION		
36 JACKSON		82 VANDERBURGH		
37 JASPER		83 VERMILLION		
38 JAY		84 VIGO		
39 JEFFERSON		85 WABASH		
40 JENNINGS		86 WARREN		
41 JOHNSON		87 WARRICK		
42 KNOX		88 WASHINGTON		
43 KOSCIUSKO		89 WAYNE		
44 LAGRANGE		90 WELLS		
45 LAKE		91 WHITE		
46 LAPORTE		92 WHITLEY		
		97 OUT OF STATE		